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No.

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IN THE

Supreme Court of the United States

October Term, 1994

MARK CHASSIN, M.D., in his capacity as New York State Commissioner of Health; LORNA H. MCBARNETTE, in her capacity as New York State Executive Deputy Commissioner of Health; STEVEN C. ANDERMAN, in his capacity as Deputy Director, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

against

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS and PETER VICKERS,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether N.Y. Pub. Health Law § 2807-d, which imposes a tax of six-tenths of one percent on the gross receipts from patient care services and other operating income of all hospitals in New York State, is preempted by § 514(a) of the Employee Retirement Income Security Act, 29 U.S.C. § 1144(a), insofar as it applies to the income of medical centers operated by an ERISA fund?

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IN THE

Supreme Court of the United States

October Term, 1994

MARK CHASSIN, M.D., in his capacity as New York State Commissioner of Health; LORNA H. MCBARNETTE, in her capacity as New York State Executive Deputy Commissioner of Health; STEVEN C. ANDERMAN, in his capacity as Deputy Director, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

against

NYSA-ILA MEDICAL and CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Petitioners Mark Chassin, M.D.,[1] Commissioner of Health of the State of New York, Lorna H. McBarnette, Executive Deputy Commissioner of Health of the State of New York, and Steven C. Anderman, Deputy Director, Division of Health Care Financing, Office of Health Systems Management (collectively referred to herein as the "State"), respectfully pray that a writ of certiorari

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[1] Mark Chassin, M.D., successor to David Axelrod, M.D., as Commissioner of Health of the State of New York, has been automatically substituted as a party pursuant to Fed. R. App. P. Rule 43(c).

issue to review the judgment of the United States Court of Appeals for the Second Circuit, entered on June 23, 1994. [2]

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit is reported at 27 F.3d 823 (2d Cir. 1994) and is reprinted in the appendix to the petition at A-1 to A-11.[3] The memorandum opinion and order of the United States District Court for the Southern District of New York (Martin, D.J.) is not reported and is reprinted at A-12 to A-19.

JURISDICTION

The judgment of the court of appeals was entered on June 23, 1994. This Court granted petitioners' request for an extension of time to file a petition for a writ of certiorari on September 14, 1994, extending the time to file the petition to and including October 21, 1994 (A-22). This petition is filed within the time provided by the Court's order. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTES INVOLVED

The applicable statutes are reproduced in the appendix at A-23 to A-24. The relevant federal statutory provision is § 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a). The relevant New York State statutes are N.Y. Pub. Health Law §§ 2801(1), 2807-d(1)(a), and 2807-d(2)(c).

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[2] The caption of this case in this Court contains the names of all parties to the proceeding.

[3] References to the appendix attached to the petition are cited as "A-_". References to the joint appendix filed in the United States Court of Appeals for the Second Circuit are cited as "JA__."

STATEMENT OF THE CASE

A. The Hospital Assessment

In 1990, in order to offset increased health care costs, the New York State Legislature enacted section 2807-d of the New York Public Health Law, entitled "Hospital Assessments".[4] 1990 N.Y. Laws, ch. 938.[5] The assessment was enacted as an alternative to substantial Medicaid payment reductions which would otherwise have been required (JA 51, 59).

The assessment is charged to all "hospitals" as defined in the Public Health Law. N.Y. Pub. Health Law § 2807-d(1)(a) (McKinney 1993). The Public Health Law defines "hospital" to encompass generally any facility engaged in providing services under the supervision of a physician or dentist, and includes diagnostic centers and treatment centers. N.Y. Pub. Health Law § 2801(1) (McKinney 1993).

The assessment, six-tenths of one percent for diagnostic and treatment centers, applies with limited exceptions to a covered facility's gross receipts from patient care services and other operating income. N.Y. Pub. Health Law §§ 2807-d(1)(a), 2807-d(2)(c) (McKinney 1993). Assessable income has been further defined by the New York State Department of Health to include all cash receipts from patient care services irrespective of payment source, investment income, and other operating income, such as non-patient food sales, parking revenue, medical records fees, and the like (JA 65). Reports of assessable income and the assessments are required to be forwarded on a monthly basis to an administrative agent appointed by the New York State Department

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[4] The assessment is referred to by the courts below as the Health Facility Assessment or "HFA."

[5] The assessment, as originally enacted, was to expire on April 1, 1992, but was amended to remain in effect after that date. 1992 N.Y. Laws, ch. 41, §§ 54, 163.

of Health which, in turn, transmits those monies to the State's general fund (JA 57).

Respondents, trustees of the NYSA-ILA Medical and Clinical Services Fund (collectively referred to herein as the "Fund"), operate two medical centers in New York State licensed by the New York State Department of Health as diagnostic and treatment centers under N.Y. Pub. Health Law § 2805 (McKinney 1993). The centers provide medical, dental and related health care benefits on an outpatient basis to Fund participants and beneficiaries, primarily longshore workers and their dependents (JA 78-79). The medical centers' income is derived from a number of different sources, including employer contributions pursuant to collective bargaining agreements remitted to the Fund and transferred to the medical centers, fee-for-service payments made directly to the medical centers, employee co-payments for services, payments from workers' compensation carriers, and miscellaneous sources, such as supplier rebates and medical records fees (JA 80-82, 85).

The medical centers filed reports and paid assessments for the period from January 1, 1991 through November 30, 1991 (JA 84-85, 135-141). The centers did not include in their reported assessable income any monies which were transferred to them from the Fund (JA 84), and the State did not contest that exclusion. The centers reported as assessable income only employer payments to the centers, payments from workers' compensation carriers, fee-for-service payments from a separate fund, and employee payments for certain services, as well as miscellaneous income (JA 84). For the period from January 1, 1991 through November 30, 1991, the centers reported assessable income of $1,177,670 and paid assessments totaling $7,066.02 (JA 84-85).[6] Thereafter, the centers discontinued filing reports and paid no further assessments (JA 86).

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[6] Total revenue for the Fund in 1991 was $20,267,226 (JA 89).

B. Prior Proceedings

On April 16, 1992, the Fund commenced this action for declaratory and injunctive relief and for a refund of the assessments already paid on the ground that the hospital assessment is preempted by ERISA (JA 18-23). The parties cross-moved for summary judgment pursuant to Fed. R. Civ. P. Rule 56.

The district court granted the State's motion, determining that the hospital assessment is not preempted by ERISA because it is a law of general application with only an incidental economic impact on ERISA plans (A-17-18).[7] Pointing to the *de minimis* amount of the assessment, the court distinguished this case from *Travelers Insurance Company v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y.), *aff'd*, 14 F.3d 708 (2d Cir. 1993), *cert. granted*, 63 U.S.L.W. 3281 (October 11, 1994) (Docket Nos. 93-1408, 1414, 1415), in which three New York State surcharges imposed on hospital bills of varying amounts of 9%, 11%, and 13% depending on whether the bills are paid by commercial insurers, health maintenance organizations (HMOs), or other specified payors, was invalidated as ERISA-preempted (A-18).

On June 23, 1994, the Court of Appeals for the Second Circuit reversed the district court. The court of appeals stated that because "the HFA targets only the health care industry" which is, "by definition, the realm where ERISA plans must operate [the assessment] was bound to affect them" (A-8). Thus, the court determined that the assessment "directly affects" the Fund and distinguished it from other laws of general applicability (A-8).

Relying on its decision in *Travelers Insurance Co. v. Cuomo*, 14 F.3d 708, the court held that the assessment "relates to" the Fund by reducing assets available to provide health care benefits, thereby causing the Fund to reduce benefits provided or to charge

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[7] The district court did not reach the other issues raised by the State, namely, that the Tax Injunction Act, 28 U.S.C. § 1341, bars the complaint and that the claim for a refund is barred by the Eleventh Amendment to the United States Constitution.

beneficiaries more (A-9). The court rejected the State's argument that, unlike *Travelers* which involved surcharges on hospital bills of up to 24 percent for certain ERISA plans, the amount of the hospital assessment, six-tenths of one percent, was too insubstantial to trigger preemption. According to the court of appeals, the impact of the assessment "will detrimentally affect the central mission and purpose of the Fund and hence cannot be characterized as remote and tenuous" (A-9).[8]

REASONS FOR GRANTING THE WRIT

A. The Decision Of The Court Of Appeals, In Relying On The *Travelers* Decision, Misreads Supreme Court Precedent And Conflicts With A Decision Of The Third Circuit Court Of Appeals

In light of this Court's grant of the petition for a writ of certiorari in *Travelers Insurance Company v. Cuomo*, 14 F.3d 708 (2d Cir. 1993), *cert. granted*, 63 U.S.L.W. 3281 (October 11, 1994), the decision of the Second Circuit in this case, resting as it does on the reasoning of *Travelers*, merits review.

In *Travelers*, the court of appeals invalidated three State surcharges which are part of the State's comprehensive system for regulating hospital charges as imposing a significant economic burden on commercial insurers and HMOs, thereby having an impermissible impact on the structure and administration of ERISA plans. 14 F.3d at 721. The court of appeals found that the surcharges were designed to increase hospital costs for patients covered by certain ERISA plans and substantially increased the cost to ERISA plans of providing a given level of health care benefits. 14 F.3d at 719-20.

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[8] Addressing the Fund's statement that it could avoid the tax altogether by funnelling all medical center income through the Fund, the court held that "such a restructuring would alter the Fund's established method of administration" and would be preempted by ERISA (A-9-10).

In this case, relying on its *Travelers* decision for the proposition that a law which increases the costs of an ERISA plan has the "requisite connection" to ERISA to be preempted, the court of appeals held that the hospital assessment is preempted because it depletes the assets of the Fund, thereby causing it to reduce benefits or to charge beneficiaries more. No decision of this Court, or of any of the other circuit courts of appeal, has made economic impact the litmus test for ERISA preemption.[9]

Indeed, the United States Solicitor General recognized in his brief *amicus curiae* submitted to this Court in support of the petition for a writ of certiorari in the *Travelers* case that the *Travelers* decision directly conflicts with the decision of the Third Circuit in *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179, *cert. denied*, 114 S.Ct. 382 (1993) (Brief for the United States as Amicus Curiae, p. 10).[10] Under the test established by the Third Circuit, a state

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[9] Although the Second Circuit cited *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S.Ct. 585 (1991) as a case where economic impact alone triggered ERISA preemption, that case is different. It involved a state tax imposed specifically on persons rendering services to any "employee-employer health plan" and held the plan ultimately liable for the tax. Thus, the impact of the tax was not an indirect economic one because the tax was targeted at and applied almost exclusively to ERISA plans. As discussed *infra*, p. 9, the impact of the assessment in this case is an indirect one because it does not apply to plans but is generally applicable to hospitals, regardless of whether they are operated by ERISA plans, and covers generally all hospital income irrespective of source.

[10] The Third Circuit recently opined that it is not clear whether *Travelers* conflicts with *United Wire* because the New Jersey rate-setting scheme "might more legitimately be regarded as one of general application rather than one specifically affecting ERISA plans." *Keystone Chapter, Assoc. Builders and Contractors, Inc. v. Foley*, 2 Wage & Hour Cases 2d 495 (BNA), 1994 WL 513971, *13 FN18 (Sept. 22, 1994). However, analysis of the New Jersey laws shows them to be indistinguishable from the New York State laws in *Travelers*. The New Jersey scheme gave

(continued...)

law with an indirect economic impact on plans is preempted by ERISA only

> if its effect is to dictate or restrict the choices of ERISA plans with regard to their benefits, structure, reporting and administration, or if allowing states to have such rules would impair the ability of a plan to function simultaneously in a number of states.

United Wire, 995 F.2d at 1193.[11] In *United Wire*, the court rejected the proposition utilized by the Second Circuit in *Travelers*, that laws which have a solely economic impact on ERISA plans are necessarily preempted.

The Third Circuit's guidelines, unlike the Second Circuit's, are soundly based on the decisions of this Court that a law of general applicability is not preempted merely because it results in "substantial administrative burdens and costs" to benefit plans. *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 831 (1988). In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the court, in upholding preemption of a state wrongful

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[10](...continued)
discounts to high-volume plans and for open enrollment practices which benefitted Blue Cross plans and then increased the hospital bills of patients who did not belong to those plans to make up for revenue lost through such discounts. *United Wire*, 995 F.2d at 1190. The New York State scheme imposed surcharges on hospital bills paid by payors other than Blue Cross plans. *Travelers*, 14 F.3d at 712.

[11] The Third Circuit also recognized, based upon this Court's decisions, that a state law is preempted by ERISA if it is "specifically designed to affect" plans, or "singles out such plans for special treatment," or if the state law is "predicated on the existence" of a plan. 995 F.2d at 1192 (citations omitted). As discussed *infra*, p. 9, the hospital assessment involved in this case has no such direct effect on ERISA plans since it is designed solely to tax the income of "hospitals" without regard to whether they are owned or operated by an ERISA plan. Moreover, there is no evidence in the record that any particular number of hospitals are owned or operated by ERISA plans.

discharge claim, noted that it was not dealing with "a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan" or one which imposed a "mere administrative burden." *Id.* at 139.

The application of the *Travelers* economic impact test to this case invalidated a *de minimis* tax on hospital income because of the costs imposed by the tax on an ERISA plan, which is affected by the tax only because the plan operates medical centers which are subject to the tax. While acknowledging the *de minimis* amount of the assessment, the Second Circuit discounted that because, in its view, the assessment "directly affects" the Fund because the Fund itself operates the medical centers (A-8). That fact, however, does not make the state law one which has a "direct" effect on ERISA plans, since it is not targeted at, or specifically designed to affect, ERISA plans. The hospital assessment "makes no reference to, [and] functions irrespective of, the existence" of ERISA plans. *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 139. *See* Brief for the United States as Amicus Curiae in *Travelers*, p. 13 (effect of New York State surcharges is indirect because they do not apply to plans themselves, but are generally applicable to insurers and other health carriers whose services are purchased by ERISA plans and others).

Moreover, the Second Circuit's analysis would result in broad preemption of State health care regulations, not only as applied to hospitals operated by ERISA funds. As the court of appeals noted in the *Travelers* decision, in preempting surcharges that applied to all payors of hospital bills, "[e]ighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans." 14 F.3d at 711. Thus, any hospital tax or assessment, indeed the cost of any health care regulation, will be borne in large measure by ERISA plans because, as the Second Circuit stated in this case, "that is the realm in which ERISA plans must operate" (A-8). Significantly, since the court of appeals rejected the view that its *Travelers* decision applies only to *substantial* economic impact, as opposed to *de minimis* impact (A-11), it is more than likely that any State

regulation in the health care field would risk ERISA-preemption insofar as it increased the costs of any ERISA plans.

The Second Circuit also concluded wrongly that, in addition to the depletion of Fund assets which warranted preemption, the fact that the Fund could avoid the assessment altogether by funnelling all income through it to the centers, justified preemption because that "would require it to implement procedures for its New York facilities that differ from those of its New Jersey facility" (A-9-10). While there is no evidence in the record to support that conclusion, such a change, if made by the Fund, would not be one which this Court or any other circuit court of appeal has held to warrant preemption because it would not be necessitated by the state law. In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, the plan argued that the economic impact of garnishment of plan benefits would affect its mode of operation, but that was insufficient to justify preemption. In contrast, under the Second Circuit's analysis, any changes made by the Fund in response to generally applicable regulation to lower or minimize its costs would result in preemption. For example, the Fund's choice, in response to the burden of unemployment insurance taxes, to utilize part-time independent contractors instead of hiring its own employees to staff the clinic would likewise be ERISA-preempted.

In establishing a test for ERISA preemption based solely upon a law's economic impact, the court of appeals ignored the concern which preemption was intended to address, of avoiding a "patch-work scheme of regulation" by the States which would interfere with multi-state plan administration. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987). A generally applicable state tax of a *de minimis* amount does not interfere with plan uniformity because it does not subject the plan to any substantive obligations. Such a law does not deprive ERISA plans of any alternatives they would otherwise have or require them to structure their benefits or conduct their internal affairs in any particular way. On the contrary, the effect of such a law is the same as that which results from numerous forms of state regulation which result in increases in the cost of doing business, such as unemployment taxes, sales

taxes, utility costs, or minimum wage laws. Since the cost of doing business must necessarily vary from state to state, state laws which affect those costs do not interfere with the interstate operation of ERISA plans.

B. This Case Presents Substantial And Pressing Questions Of National Significance

This case is of great importance because it deals with the right of States to devise appropriate means to finance health care and because the breadth of the Second Circuit's decision threatens all State regulation of the health care field.

Health care is a subject of increasing national concern. Even before the discussion on national health care reform took center stage, many States were exploring ways to address the problems of health care access, equity in financing and coverage, and expenditure growth. Health care has traditionally been left to State control. *Hillsborough County v. Automated Medical Lab., Inc.*, 471 U.S. 707, 719 (1985). One of the most pressing issues facing States seeking to ensure adequate health care coverage is how to pay for it and who will bear the financing burden. One method of financing the cost of health care is an assessment on hospitals or health care providers of the sort which New York State has enacted in N.Y. Pub. Health Law § 2807-d. At least five other States utilize the same kind of financing mechanism.[12] Numerous other States employ other types of methods to address health care access and affordability. *See* 138 Cong. Rec. S13269 (Sept. 10, 1992). The validity of all of these regulatory schemes is threatened by the court of appeals' decision. *See, e.g., New England Health Care Employees v. Mount Sinai Hospital*, No. 292 CV 01012 (D. Conn., Feb. 25, 1994) (preempting Connecticut's Uncompensated Care Pool financed by an assessment on hospital revenues).

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[12] Colo. Rev. Stat. § 26-4-417 (1991); Conn. Gen. Stat. Ann. § 19a-168 (West 1991); Fl. Stat. Ann. § 408.20 (West 1992); Haw. Rev. Stat. § 323-73 (1989); 33 Vt. Stat. Ann. § 1953 (1991).

The breadth of the court of appeals' decision is sweeping. The assessment was invalidated because, the court stated, it "targets only the health care industry" which "by definition" is the realm where ERISA plans must operate (A-8). Were this view to prevail, there would be virtually no room for States to regulate in the health care field. Numerous State laws and regulations setting standards for the delivery of health care services, from staffing requirements to nursing standards, would be invalidated. The Third Circuit Court of Appeals in *United Wire* pointed to the example of State regulation of the disposal of medical wastes. As that court stated, "[s]uch regulations can significantly increase a hospital's cost of doing business... ." *United Wire*, 995 F. 2d at 1196. Yet, the Third Circuit concluded that such an impact is insufficient to trigger ERISA preemption. Under the Second Circuit's economic impact test, such laws would likely be preempted.

In 1985, the Second Circuit, in a decision it abandoned in the *Travelers* decision, warned that too expansive an interpretation of ERISA's preemption provision would result in a "fully insulated legal world that excludes these plans from regulation of any purely local transaction." *Rebaldo v. Cuomo*, 749 F.2d 133, 149, *cert. denied*, 472 U.S. 1008 (1985). The adoption and use of an economic impact test to determine the scope of ERISA preemption will create such an insulated world and goes far beyond what Congress intended in enacting the preemption provision. The Court should grant the petition to review this important question.

CONCLUSION

FOR THE FOREGOING REASONS, THE PETITION FOR A WRIT OF CERTIORARI SHOULD BE GRANTED.

Dated: New York, New York
October 21, 1994

Respectfully submitted,

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APPENDIX

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UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 1294—August Term 1993

(Argued March 10, 1994 Decided June 23, 1994)

Docket No. 93-7221

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, By Its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, and PETER VICKERS,

Plaintiffs-Appellants,

—v.—

DAVID AXELROD, M.D., in his capacity as New York State Commissioner of Health; LORNA H. MCBARNETTE, in her capacity as New York State Executive Deputy Commissioner of Health; STEVEN C. ANDERMAN, in his capacity as Deputy Director, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Defendants-Appellees.

Before:

WALKER and JACOBS, *Circuit Judges*, and ZAMPANO, *District Judge*.*

Appeal by trustees of ERISA Fund from a judgment of the United States District Court for the Southern District of New York (Martin, *J.*), holding that ERISA did not preempt New York state tax on gross receipts of medical centers operated by the Fund.

Reversed.

DONATO CARUSO, New York, New York (C. Peter Lambos, Lambos & Giardino, New York, New York; Thomas W. Gleason, Ernest L. Mathews, Jr., Kevin Marrinan, Gleason & Mathews, New York, New York, *of counsel*), *for Plaintiffs-Appellants*.

JANE LAUER BARKER, Ass't Attorney General, New York, New York (G. Oliver Koppell, Attorney General of the State of New York, *of counsel*), *for Defendants-Appellees*.

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[1] Honorable Robert C. Zampano, United States District Judge for the District of Connecticut, sitting by designation. Judge Zampano retired shortly after oral argument was heard in this case. Accordingly, the appeal was decided by the remaining panel members pursuant to Section 0.14 of the Local Rules of the Second Circuit.

WALKER, *Circuit Judge*:

The Trustees of NYSA-ILA Medical & Clinical Services Fund (the "Fund") brought this suit seeking a declaration that the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, preempts New York Public Health Law § 2807-d to the extent the latter provision taxes contributions and other payments for health care benefits received by two medical centers operated by the Fund. The Fund now appeals from a judgment of the United States District Court for the Southern District of New York (John S. Martin, Jr., *Judge*) holding that ERISA does not preempt the state tax and granting summary judgment to defendant state health care officials. We reverse.

BACKGROUND

The Fund is an ERISA-regulated multiemployer, labor-management trust fund established through collective bargaining to administer an employee welfare benefit plan that provides medical, dental, and other health care services to ERISA plan participants, consisting primarily of longshore workers, and their dependents. The Fund provides these health care benefits through three medical centers that it owns and operates, two in New York and one in New Jersey. The centers provide treatment exclusively to plan participants and beneficiaries.

In 1990, the State of New York enacted a Health Facility Assessment ("HFA"), which imposed a tax on the gross receipts from patient care services and general operations of all hospitals in New York State. N.Y. Pub. Health Law § 2807-d. The HFA was enacted to help eliminate the State's budget deficit for the 1990-91 fiscal year. The HFA became effective January 1, 1991, and was sup-

posed to expire on April 1, 1992, but has subsequently been amended to remain in force on and after that date. 1992 N.Y. Laws, ch. 41, §§ 54, 163. The HFA applies to a wide range of medical facilities, including diagnostic and treatment centers such as the medical centers operated by the Fund. N.Y. Pub. Health Law § 2801(1). The amount of the assessment, which varies by type of facility, is six-tenths of one percent for the Fund's medical centers. *Id.* § 2807-d(2)(c). For purposes of the assessment, "gross receipts" are defined as "all monies received for or on account of hospital and health related services" with only limited exceptions. *Id.* § 2807-d(3)(c).

The Fund's medical centers receive income from a variety of sources. The bulk of their costs are covered by employer contributions remitted to the Fund which are then transferred to the centers on an as-needed basis to pay for the centers' payroll and other operating expenses. However, the centers obtain additional revenue from certain employer payments made directly to the centers, employee co-payments, other fee-for-service payments, patient registration fees, payments from workers' compensation carriers, and such miscellaneous sources as the sale of scrap or waste, fees for reproducing medical records, and supplier rebates. For the period from January 1, 1991 to November 30, 1991, the Fund's two New York medical centers reported combined assessable income of $1,177,670 and paid assessments totalling $7,066. The Fund discontinued filing HFA reports with the New York State Department of Health after November 1991 and has paid no assessments since that time.

The medical centers did not include in their assessable income monies transferred from the Fund to the centers, and the State defendants have not contested the exclusion of these payments in this case. However, the question of

whether monies transferred from the Fund to the centers are assessable has never, to our knowledge, been litigated or definitively resolved. Since early 1992, the Fund has restructured its payment procedures so that certain employer contributions and registration fees that were formerly paid directly to the medical centers are now remitted to the Fund itself. The Fund believes that this restructuring avoids the effect of the HFA, but is unwilling to redirect to the Fund all payments now received by the medical centers until this case has been decided.

The Fund instituted this suit in April 1992 asserting that ERISA preempts the HFA insofar as it imposes a levy on contributions and payments for health care benefits provided by the Fund. The Fund does not challenge imposition of the HFA on the centers' miscellaneous revenue earned from activities unrelated to the health care services provided to participants and beneficiaries, such as the income derived from the sale of scrap, records reproduction fees, and supplier rebates. The Fund sought declaratory and injunctive relief as well as restitution of a substantial portion of the HFA assessments it had previously paid.

On cross-motions for summary judgment, the district court ruled that the HFA is a tax of general application that is not preempted by ERISA because it has only an incidental impact on ERISA plans. The district court reasoned that the minimal tax imposed by the HFA "is not great enough to pose a serious economic threat to the plan which might trigger preemption." *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, 92 Civ. 2279 (JSM), slip op. at 8 (S.D.N.Y. Feb. 18, 1992). Accordingly, the district court entered judgment dismissing the action and this appeal ensued. We review the district court's decision *de*

novo. *See Westinghouse Elec. Corp. v. New York City Transit Auth.*, 14 F.3d 818, 821 (2d Cir. 1994).

DISCUSSION

ERISA was enacted in 1974 "to promote the interests of employees and their beneficiaries in employee benefit plans," including both pension and welfare plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). An "employee welfare benefit plan" is defined in the statute as

> any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . .

29 U.S.C. § 1002(1). The parties do not dispute that the Fund qualifies as an employee welfare benefit plan that fulfills its institutional mission by providing medical benefits directly to plan participants and their beneficiaries through Fund-operated medical centers.

One of ERISA's main objectives was to eliminate state regulation of employee benefit plans. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990); *Shaw*, 463 U.S. at 99 (quoting legislative history). To accomplish this, Congress enacted an express preemption clause that is "deliberately expansive." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987). It provides that ERISA "shall supersede any and all State laws insofar as they may now

or hereafter relate to any employee benefit plan" covered by the law. 29 U.S.C. § 1144(a). The Supreme Court has observed that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw*, 463 U.S. at 96-97. Preemption thus applies even where a state law was not specifically designed to regulate the terms and conditions of employee benefit plans or does not relate to those subjects covered by ERISA, such as reporting, disclosure, and fiduciary responsibilities. *See Ingersoll-Rand Co.*, 498 U.S. at 137-39; *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990); *Shaw*, 463 U.S. at 98. Indeed, even where a state law has no express link to an employee benefit plan, it can be preempted " 'insofar as' the law applies to benefit plans in particular cases." *Morgan Guar. Trust Co. v. Tax Appeals Tribunal*, 80 N.Y.2d 44, 49 (1992) (quoting *Shaw*, 463 U.S. at 97 n.17).

ERISA preemption is not without limitations, however. The Supreme Court has recognized that ERISA preemption will not apply to state laws that "affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. When it announced this limitation, the Court "express[ed] no views about where it would be appropriate to draw the line," *id.*, but it has subsequently observed that this limitation will apply "with many laws of general applicability," *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 583 n.1 (1992). There are a number of cases that bear out this observation. *See, e.g., Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (generally applicable garnishment law not preempted); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) (state law requiring one-time severance payment not preempted); *Aetna*

Life Ins. Co. v. Borges, 869 F.2d 142 (2d Cir.) (state escheat law not preempted when applied to recover unclaimed ERISA plan benefits), *cert. denied*, 493 U.S. 811 (1989); *see also Matter of Dyke*, 943 F.2d 1435, 1447 (5th Cir. 1991) (collecting cases). Unfortunately, these decisions have provided no sure method for determining whether the HFA's impact on the Fund is too "tenuous, remote, or peripheral" to trigger ERISA preemption.

The State argues that the HFA is a state tax law of general application that affects ERISA plans only incidentally. According to the State, the HFA is no more directed at ERISA plans than laws implementing sales taxes, utility taxes, and gasoline taxes, and should thus be seen simply as a "cost of doing business" within the state. Relying on *Mackey* and *Aetna Life Ins. Co.*, the State contends that the HFA should not be preempted because it covers ERISA plans only by virtue of the plans' inclusion in a broader class of entities subject to regulation.

However, we believe that the HFA is distinguishable from these laws of general application. The HFA does not apply broadly to every sector of society in New York; nor does it apply to the Fund simply because it engaged in certain kinds of activities which any other member of society might engage in, such as purchasing gasoline or paying one's employees. Rather, the HFA targets only the health care industry. Because this industry is, by definition, the realm where ERISA welfare plans must operate, the HFA was bound to affect them. In a case such as the present one where the plan has chosen to provide medical benefits through self-run medical centers, the HFA operates as an immediate tax on payments and contributions which were intended to pay for participants' medical benefits. The HFA thus directly affects the Fund in its principal role as an employee welfare benefit plan. It does not

touch the Fund only slightly on the outer limits of its plan activities; it affects the very operations and functions that make the Fund what it is, a provider of medical, surgical, and hospital care to its participants and their beneficiaries.

We thus conclude that the HFA "relates to" the Fund and does so in a very direct way. The tax depletes those assets earmarked for the provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received. Both impacts will detrimentally affect the central mission and purpose of the Fund and hence cannot be characterized as remote or tenuous. *See Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 720 (2d Cir. 1993) ("[T]he surcharges here force ERISA plans to increase either plan costs or reduce plan benefits. Therefore, they have the requisite connection to ERISA."), *petition for cert. filed*, 62 U.S.L.W. 3625 (U.S. Mar. 9, 1994) (No. 93-1414); *E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1103 (5th Cir.) ("The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation."), *cert. denied* 112 S. Ct. 585 (1991).

Our decision would remain the same even if we assumed that the Fund could avoid the HFA by restructuring its finances so that funds formerly remitted by plan participants and employers directly to the medical centers would be remitted to the Fund which would subsequently transfer them to the centers. Wholly apart from whether the transmission of assets from the Fund to the centers could be taxed without running afoul of ERISA preemption, an issue we need not and do not decide, such a restructuring would alter the Fund's established method of

administration and would require it to implement procedures for its New York facilities that differ from those of its New Jersey facility. Moreover, these changes would not be insignificant since they would affect the Fund's primary means of collecting contributions and paying for benefits. A state law that "relates to" an ERISA plan is not saved from ERISA preemption by the fact that a plan could restructure its operations to avoid the impact of the state law. Requirements under state law that force plans to change their traditional methods of administration or to adopt different methods on a state-by-state basis are features of state regulation that ERISA was designed to prevent. *See FMC Corp.*, 498 U.S. at 59-60; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981); *National Carriers' Conference Comm. v. Heffernan*, 454 F. Supp. 914, 918 (D. Conn. 1978) (Newman, J.). *Compare Aetna Life Ins. Co.*, 869 F.2d at 147 (discounting Fund's complaint that it would need to make administrative and accounting adjustments in order to comply with state escheat law because the impact was not substantial enough).

The district court acknowledged that the HFA will directly impact the Fund by leaving less money for benefits, but determined that the magnitude of the impact was too insubstantial to trigger preemption since the tax rate was only .6%. We do not agree with this reasoning. The magnitude of a statute's economic impact on employee benefit plans may enter the analysis where the statute's connection to the ERISA plan is otherwise insufficient for preemption. For example, a real estate gains tax that has only a peripheral connection to ERISA plans may still be subject to preemption if the high rate of tax has a substantial economic impact on a plan. *See Morgan Guar. Trust Co.*, 80 N.Y.2d at 51-53 (ten percent tax on gain

from ERISA plan's sale of real property preempted because of direct impact on plan's administration and investment strategy). However, the converse is not true. A statute that "relates to" ERISA plans cannot escape preemption simply because the magnitude of the impact is thought to be insubstantial. Adopting such an approach would contravene the policy that underlies the preemption provision of protecting ERISA plans from state regulation and would open the door to endless litigation about what constitutes a "substantial" impact.

Travelers Insurance Co. v. Cuomo, *supra*, is not to the contrary. In that case, we held that New York surcharges on hospital rates were preempted by ERISA to the extent ERISA plans must pay surcharges. In the course of our analysis, we discussed Judge Martin's opinion in this case without criticizing it. However, we cited it only for the proposition that "a *substantial* economic impact, standing alone, could be enough to bring ERISA's preemption clause into play." 14 F.3d at 721. We did not endorse—and now expressly refuse to endorse—the converse proposition urged by the State: that a regulation which has a *de minimis* economic impact on ERISA plans may withstand preemption regardless of what plan operations it affects.

For the foregoing reasons, we reverse the judgment of the district court.

MEMORANDUM OPINION AND ORDER

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

92 Civ. 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES: JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiff,

-v.-

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; AND STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

JOHN S. MARTIN, JR., District Judge:

Plaintiff and defendants have moved for summary judgment. The central question presented by these motions is whether the Employment Retirement Income Security Program (ERISA), 29 U.S.C.A. §§ 1001-1461 (1985 & Supp. 1992), preempts the State of New York's Health Facility Assessment (HFA), N.Y. PUB. HEALTH LAW § 2807-d (McKinney Supp. 1992).

The HFA, a state tax of general application, is an assessment charged on gross receipts of hospitals. *Id.* § 2807-d(1). Plaintiff is an ERISA plan which operates medical centers for the benefit of its plan beneficiaries. New York currently applies the HFA to plaintiff's medical centers. Plaintiff claims that its medical centers should not be subject to the tax because ERISA preempts state laws, such as the HFA, which affect ERISA plans. Plaintiff also seeks to recover the tax it has thus far paid under the HFA.

Defendants move for dismissal on grounds that the Tax Injunction Act, 28 U.S.C.A. § 1341 (1976), prevents this Court from ordering injunctive relief which interferes with a state tax plan. Defendants also move in the alternative for summary judgment on plaintiff's claims.

Defendants' motion for summary judgment is granted because ERISA does not preempt the Health Facility Assessment.

DISCUSSION

Defendants first question this Court's jurisdiction over this case. ERISA provides that actions concerning ERISA preemption of state laws shall be brought in the United States District Courts. 29 U.S.C.A. § 1132(e)(1). However, this jurisdictional grant is in conflict with a jurisdictional bar contained in the Tax Injunction Act (TIA). 28 U.S.C.A. § 1341 (1976). The TIA provides that "[t]he district courts shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State." *Id.* The conflict is resolved, however, in light of ERISA's provision that "nothing in [this subchapter] shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulations issued under any such law." 29 U.S.C.A. § 1144(d). This provision prevents ERISA from superseding the TIA. *Retirement Fund Trust v. Franchise Tax Bd.*, 909 F.2d 1266 (9th Cir. 1990); *Ashton v. Cory*, 780 F.2d 816, 822 (9th Cir. 1986); *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280, 1283 (D. Conn. 1977); *In re Sterling Die Casting Co., Inc.*, 118 B.R. 205,

207 (Bkrtcy. E.D.N.Y. 1990); *see also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 104-05, 103 S. Ct. 2890, 2904 (1983).

Plaintiff raises additional arguments against the TIA's applicability to this action which are unpersuasive. The Fund urges this Court to use rules of statutory construction to find that ERISA supersedes the TIA. Plaintiff notes that a more specific statute overrides one that is more general. *Morgan v. Mancari*, 417 U.S. 535, 550-51 (1974). However, the *Morgan* rule only applies where there is no clear expression by Congress as to whether the later statute is intended to supersede the earlier one. *Id.* This rule is inapplicable in this case because of the clear language of ERISA § 1144 which indicates that Congress did not want ERISA to affect other Federal law.

Plaintiff also argues that it should be allowed the benefit of an exception to the TIA. The Supreme Court has ruled that the United States is not restricted by the TIA from protecting itself and its instrumentalities from unconstitutional state exactions in federal courts. *Department of Employment v. United States*, 385 U.S. 355, 358 (1966). The Court extended this rule to allow Indian tribes an exemption from the TIA if the United States could have sued on their behalf. *Moe v. Confederated Salish and Kootenai Tribes*, 425 U.S. 463, 96 S. Ct. 1634 (1976). *Moe* grants this exception to Indian tribes in part because of the unique trustee relationship of the United States to the tribes. *Id.* at 473, 96 S. Ct. at 1641; *Federal Deposit Ins. Corp. v. State of New York*, 928 F.2d 56, 60 (2d Cir. 1991). Plaintiff misconstrues *Moe* to state that any private party is exempt from the TIA's jurisdictional bar if the United States could have sued on its behalf. *Federal Deposit Ins. Corp.*, 928 F.2d at 60. Since plaintiff is not in a trust relationship with the United States, the *Moe* exception to the TIA does not apply in this action.

There being no reason extrinsic to the TIA to bar its application to this action, it is now appropriate to consider the terms of the TIA itself. The TIA operates to bar federal courts from granting injunctions or declaratory judgments in matters affecting state tax schemes when there is a "plain, speedy and efficient remedy" to

be had in state courts. *Keleher v. New England Tel. & Tel. Co.*, 947 F.2d 547, 549 (2d Cir. 1991).

Plaintiff's arguments to the contrary notwithstanding, the HFA does fall within the class of state taxes excluded from the district courts' jurisdiction. For TIA purposes, the Second Circuit broadly defines the word "tax." *Keleher*, 947 F.2d at 549. Any state or local revenue collection device is a "tax" for purposes of the TIA. *Id.* (citing Robinson Protective Alarm Co. v. City of Philadelphia, 581 F.2d 371, 374-76 (3d Cir. 1978)). In the case at bar, the HFA is a revenue collection device of the state and is therefore a tax for TIA purposes.

Once it has been established that a state tax if at issue, federal courts do not have jurisdiction to enjoin its enforcement or declare it invalid if there is a plain, speedy and efficient remedy available in the state courts. 28 U.S.C.A. § 1341. It is not enough that the defendant may raise the invalidity of the tax as a defense to an enforcement proceeding. *Georgia R.R. & Banking Co. v. Redwine*, 342 U.S. 299, 303 n.11, 72 S.Ct. 321, 324 n.11 (1952); *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280, 1283 (D. Conn. 1977).

In New York State Courts, there are two affirmative proceedings that the taxed entity might pursue; an Article 78 proceeding and an action for declaratory judgment. However, where constitutional questions are implicated in an Article 78 proceeding, the proper procedure is for the action to be converted to one for declaratory judgment because an Article 78 proceeding is not an appropriate forum for constitutional challenges. *Board of Educ. v. Gootnick*, 427 N.Y.S.2d 777 (N.Y. 1980). Thus, in New York, an action for declaratory judgment is the only action available to the Fund to affirmatively challenge the constitutionality of the HFA.

Plaintiff asserts, however, that its claim will be dismissed in state court because ERISA grants exclusive jurisdiction over ERISA claims to the federal courts. Yet, plaintiff's speculation on the fate of its action in the state courts is discredited in light of the

fact that New York State courts regularly entertain such actions. *See, e.g., Matter of Morgan Guar. Trust Co. v. Tax Appeals Tribunal*, 587 N.Y.S.2d 252 (N.Y. 1992); *Tap Elec. Contracting Serv., Inc. v. Harnett*, 556 N.Y.S.2d 988 (N.Y. 1990); *Sasso v. Vachris*, 494 N.Y.S.2d 856 (N.Y. 1985); *United Health Servs., Inc. v. Upstate Admin. Servs., Inc.*, 573 N.Y.S.2d 851 (N.Y. Sup. Ct. 1991); *People v. Art Steel Co., Inc.*, 505 N.Y.S.2d 715 (N.Y. Crim. Ct. 1986). Nevertheless, courts have held that the uncertainty over whether New York State courts will entertain ERISA preemption actions renders the availability of a state court remedy anything but "plain." *Travelers Ins. Co. v. Cuomo*, No. 92 Civ. 3999 (LJF) (S.D.N.Y. Feb. 3, 1993); *Heffernan*, 440 F. Supp. at 1283. There is no need to decide this issue, here however, because, reaching the merits of plaintiffs, claim, I conclude that the HFA is not preempted by ERISA.

Since there are no disputed issues of material fact, this case is an appropriate one to resolve on motion for summary judgment. This case is governed by recent Second Circuit pronouncements on the extent of ERISA preemption. Although the parties make much of analogizing to, and discrediting, the Second Circuit's holding in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008, 105 S. Ct. 2702 (1985), that case does not provide the clearest guidance. The Circuit Court has since refashioned its test for ERISA preemption in light of Supreme Court rulings subsequent to *Rebaldo*, although it has not abandoned *Rebaldo*. *See Rogers v. Consolidated Rail Corp.*, 948 F.2d 858 (1991); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir. 1989), *cert. denied*, 493 U.S. 811, 110 S. Ct. 57 (1989).

While ERISA's preemption provision is to be interpreted broadly, the presumption against preemption of state law is at its strongest when dealing with a law that is within the states' traditional police powers. *Rogers*, 948 F.2d at 859; *Aetna*, 869 F.2d at 144. The Second Circuit, in conducting a survey of ERISA preemption cases has generalized from them to find that there are certain types of cases which fall on either side of the preemption line. *Aetna*, 869 F.2d at 145-46. The Circuit Court found

> that the laws that have been ruled preempted are those that provide an alternative cause of action to employees to collect benefits protected by ERISA, refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee. Those that have not been preempted are laws of general application--often traditional exercises of state power or regulatory authority--whose effect on ERISA plans is incidental.

Id. at 146. Further defining "what constitutes an incidental impact," the Circuit Court stated that indirect economic impact alone was not enough. The impact must affect the "primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit." *Id.*

Using this litmus test, the Second Circuit held in *Aetna* that a Connecticut escheat law was not preempted by ERISA. *Id.* at 147. The escheat law required that pension benefits which remained unclaimed for more than twenty years be paid to the state. ERISA had no provision for what to do with the unclaimed benefits. The court recognized that the state escheat law would have an economic impact on the benefit plan and that administrative and accounting adjustments would have to be made to comply with the state law. However, the Circuit Court held that "these indirect and administrative effects are not substantial enough [ ] to persuade us that this is the type of law that Congress intended to preempt." Thus, "[a]bsent more specific direction from Congress, we can safely assume that Congress did not intend to create an exception to this traditional exercise of state authority." *Id.*

In the case at bar, this Court is confronted with the question of ERISA preemption of a state's tax law, a traditional exercise of state authority. The HFA is a tax of general application; it is not specifically directed at ERISA plans but applies to all health care facilities. The tax does not interfere with the calculation of benefits or the determination of an employee's eligibility for benefits. The impacts on benefit plans are incidentally economic

resulting only in the need for administrative and accounting procedures to comply with the law.

The fact that the tax will leave less money for benefits is not decisive here as it was not in *Aetna*, where Connecticut's escheat laws also drained funds that might otherwise go to benefits. The tax is not great enough to pose a serious economic threat to the plan which might trigger preemption. *See Aetna, 869 F.2d at 147.* Here the tax is "sixth-tenths of one percent of each facility's gross receipts received from all patient care services and other operating income on a cash basis." N.Y. PUB. HEALTH LAW § 2807-d(2)(c). The Fund paid, for the period of January 1 through November 30, 1991, $7,066.02 as the assessment on $1,177,670 of income which is subject to the assessment out of approximately $20,000,000 (twenty million) total income for 1991. Fier Affidavit ¶ 19. While there are no numerical standards established by case law to determine how much tax is too much, it is clear that the HFA is not significant enough to warrant preemption of a state's traditional taxing power without explicit instructions from Congress.

Plaintiff notes that the New York Court of Appeals has reached a different conclusion. *Morgan*, 587 N.Y.S.2d 252. The Court of Appeals held that a state tax on gains from the transfer of real property was preempted by ERISA because it drained plan funds, caused an administrative burden that would be different than that in other states, and impacted the structure of administrative decisions on the disposal of assets. *Id.* at 256-57. However, *Morgan* is distinguishable from the case before this Court. The tax in *Morgan* was ten percent (10.0%) of the consideration received for the property sold, an amount the Court of Appeals considered significant, *Id.* at 257, as opposed to six-tenths of one percent (0.6%) in the case before this Court. The economic impact of the HFA is not as substantial as that found in *Morgan*. *Compare Travelers Ins. Co. v. Cuomo*, No. 92 Civ. 3999 (LJF) (S.D.N.Y. Feb. 3, 1993) (state surcharges of 9%, 11%, and 13% on hospital rates preempted by ERISA to the extent that ERISA plans must pay the surcharges).

Thus, it is consistent with decisions of the New York Court of Appeals, the Second Circuit, and District Courts within it, to hold that ERISA does not preempt the HFA.

Therefore, plaintiff's motion for a refund of the approximately $7,000 paid as HFA assessments is dismissed.

CONCLUSION

Defendants' motion for summary judgment dismissing the complaint is granted because ERISA does not preempt the Health Facility Assessment. Accordingly, the remainder of defendants' and plaintiff's motions are dismissed as moot.

SO ORDERED.

Dated: February 18, 1993
New York, New York

/s/ John S. Martin, Jr.
JOHN S. MARTIN, JR., U.S.D.J.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JUDGMENT

92 CIVIL 2779 (JSM)

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND BY ITS TRUSTEES: JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS, AND PETER VICKERS,

Plaintiff,

-against-

DAVID AXELROD, M.D., IN HIS CAPACITY AS NEW YORK STATE COMMISSIONER OF HEALTH; LORNA H. MCBARNETTE, IN HER CAPACITY AS NEW YORK STATE EXECUTIVE DEPUTY COMMISSIONER OF HEALTH; AND STEVEN C. ANDERMAN, IN HIS CAPACITY AS DEPUTY DIRECTOR, DIVISION OF HEALTH CARE FINANCING, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH,

Defendants.

Plaintiff and defendants having moved for summary judgment, and the said motions having come before the Honorable JOHN S. MARTIN, U.S.D.J., and the Court thereafter on February 23, 1993, having handed down its memorandum opinion and order (#71096); granting defendants' motion for summary judgment dismissing the complaint because ERISA does not preempt the Health Facility Assessment, and dismissing as moot the remainder of defendants' and plaintiff's motions, it is,

ORDERED, ADJUDGED AND DECREED: That defendants' motion for summary judgment dismissing the complaint be and it is hereby granted, and it is further.

ORDERED, that the complaint be and it is hereby dismissed because ERISA does not preempt the Health Facility Assessment, and it is further,

ORDERED, that the remainder of defendants' and plaintiff's motions be and they are hereby dismissed as moot.

DATED: NEW YORK, NEW YORK
March 1, 1993

/s/ James M. Parkison
Clerk

Supreme Court of the United States

No. A-180

MARK CHASSIN, ET AL.,

Petitioner

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, ET AL.

ORDER

UPON CONSIDERATION of the Application of counsel for the petitioner,

IT IS ORDERED that the time for filing a petition for a writ of certiorari in the above-entitled case, be and the same is hereby, extended to and including October 21, 1994.

/s/ Clarence Thomas
Associate Justice of the Supreme
Court of the United States

Dated this 14th
day of September, 1994

STATUTES

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

* * *

N.Y. Pub. Health Law § 2801(1)

* * *

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under

the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings.

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N. Y. Pub. Health Law § 2807-d. Hospital assessments

1. (a) Hospitals, as defined in this article, excluding hospitals specified in paragraph (b) of this subdivision, are charged assessments on their gross receipts received from all patient care services and other operating income, less personal needs allowances and refunds, on a cash basis in the percentage amounts and for the periods specified in subdivision two of this section. Such assessments shall be submitted by or on behalf of hospitals to the commissioner or his designee.

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2. (c) For all other facilities issued an operating certificate pursuant to section twenty-eight hundred five of this article, including diagnostic and treatment centers, the assessment shall be six-tenths of one percent of each facility's gross receipts received from all patient care services and other operating income on a cash basis beginning January first, nineteen hundred ninety-one for hospital or health-related services, including diagnostic and treatment center services.

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